Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA Maryland HCS (VAMC Baltimore - 512, VAMC Fort Howard - 512A4 and VAMC Perry Point - 512A5)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 3100

2. Estimated Number of Veterans who are Chronically Homeless: 1085

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 3100 (estimated number of homeless veterans in service area) **x chronically homeless rate (35 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1335	180
Transitional Housing Beds	250	175
Permanent Housing Beds	0	250

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue working with our partners in the community, government and HUD
Transitional living facility or halfway house	Work on possible new contracts for transitional housing both in and outside of Baltimore. Expand more services to outlying areas.
Dental care	Try and form alliances with the dental school to assist with an overflow of clients.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **14** **Non-VA staff Participants: 92.9%**
Homeless/Formerly Homeless: **21.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.36	.0%	3.47
Food	3.64	.0%	3.80
Clothing	3.79	.0%	3.61
Emergency (immediate) shelter	3.23	15.0%	3.33
Halfway house or transitional living facility	2.93	38.0%	3.07
Long-term, permanent housing	2.21	85.0%	2.49
Detoxification from substances	3.00	8.0%	3.41
Treatment for substance abuse	3.21	15.0%	3.55
Services for emotional or psychiatric problems	3.4	.0%	3.46
Treatment for dual diagnosis	2.9	.0%	3.30
Family counseling	3.17	.0%	2.99
Medical services	4.08	15.0%	3.78
Women's health care	3.36	8.0%	3.23
Help with medication	3.29	8.0%	3.46
Drop-in center or day program	2.64	8.0%	2.98
AIDS/HIV testing/counseling	3.46	.0%	3.51
TB testing	3.62	.0%	3.71
TB treatment	3.54	.0%	3.57
Hepatitis C testing	3.92	.0%	3.63
Dental care	2.43	23.0%	2.59
Eye care	2.36	15.0%	2.88
Glasses	2.36	8.0%	2.88
VA disability/pension	3.14	8.0%	3.40
Welfare payments	3.15	.0%	3.03
SSI/SSD process	3.14	.0%	3.10
Guardianship (financial)	2.86	.0%	2.85
Help managing money	2.57	8.0%	2.87
Job training	3.14	.0%	3.02
Help with finding a job or getting employment	3.29	23.0%	3.14
Help getting needed documents or identification	3.50	15.0%	3.28
Help with transportation	3.29	.0%	3.02
Education	3.64	.0%	3.00
Child care	2.08	.0%	2.45
Legal assistance	2.38	.0%	2.71
Discharge upgrade	2.77	.0%	3.00
Spiritual	3.23	.0%	3.36
Re-entry services for incarcerated veterans	2.50	.0%	2.72
Elder Healthcare	3.14	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.00
Co-location of Services - Services from the VA and your agency provided in one location.	1.85
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.92
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.46
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.15
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.54
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.23
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.77
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.08
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.38

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.31

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Martinsburg, WV - 613

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 210

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 210 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	53	32
Transitional Housing Beds	153	17
Permanent Housing Beds	39	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transportation	Budget allocations for 2006 include funds for community bus transit system. Continue advocating for additional routes and stops which is reinforced through expanded veteran use.
Dental care	Dental care is a priority. However, it appears that no new resources in this community have been developed. We plan to promote Public Law 107-95 for dental services for veterans in VA GPD programs.
Transitional living facility or halfway house	Eight new beds are planned to open for veterans working with the CWT program. Continue to promote community agencies to enter into the GPD program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **28 Non-VA staff Participants: 82.1%**
Homeless/Formerly Homeless: **17.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.65	4.0%	3.47
Food	3.93	.0%	3.80
Clothing	3.89	.0%	3.61
Emergency (immediate) shelter	3.48	13.0%	3.33
Halfway house or transitional living facility	3.07	35.0%	3.07
Long-term, permanent housing	2.50	38.0%	2.49
Detoxification from substances	3.78	.0%	3.41
Treatment for substance abuse	3.70	13.0%	3.55
Services for emotional or psychiatric problems	3.5	9.0%	3.46
Treatment for dual diagnosis	3.3	.0%	3.30
Family counseling	2.81	.0%	2.99
Medical services	3.85	.0%	3.78
Women's health care	3.08	.0%	3.23
Help with medication	3.35	.0%	3.46
Drop-in center or day program	2.27	4.0%	2.98
AIDS/HIV testing/counseling	3.92	.0%	3.51
TB testing	4.08	.0%	3.71
TB treatment	3.81	.0%	3.57
Hepatitis C testing	3.92	.0%	3.63
Dental care	2.04	26.0%	2.59
Eye care	2.38	.0%	2.88
Glasses	2.58	.0%	2.88
VA disability/pension	3.58	4.0%	3.40
Welfare payments	3.19	.0%	3.03
SSI/SSD process	3.63	4.0%	3.10
Guardianship (financial)	2.23	4.0%	2.85
Help managing money	2.23	9.0%	2.87
Job training	3.00	35.0%	3.02
Help with finding a job or getting employment	3.48	22.0%	3.14
Help getting needed documents or identification	3.30	4.0%	3.28
Help with transportation	2.22	54.0%	3.02
Education	2.65	9.0%	3.00
Child care	2.04	9.0%	2.45
Legal assistance	2.35	.0%	2.71
Discharge upgrade	3.17	.0%	3.00
Spiritual	3.58	.0%	3.36
Re-entry services for incarcerated veterans	2.72	13.0%	2.72
Elder Healthcare	2.73	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.57
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.78
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.04
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.35
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.43
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.57
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.91
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.39
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.30
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.39
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.78

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.26
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Washington, DC - 688

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2400

2. Estimated Number of Veterans who are Chronically Homeless: 912

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2400 (estimated number of homeless veterans in service area) **x chronically homeless rate (38 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	25	170
Transitional Housing Beds	351	20
Permanent Housing Beds	11	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Increase referrals to Shelter Plus Care, Pathways and other community housing agencies. Increase collaboration with community service agencies.
Help finding a job or getting employment	Increase referrals to CWT/Veterans Industry, One-stop centers in the area, the All Faith Consortium and the Peoples Involvement Corporation (PIC).
Job training	Increase referrals to CWT/Veteran's Industry, DC Apprenticeship Office, DC/VA Vocational Rehabilitation and one-stop centers.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **40** **Non-VA staff Participants: 42.9%**
Homeless/Formerly Homeless: **27.5%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.29	.0%	3.47
Food	3.50	3.0%	3.80
Clothing	3.53	3.0%	3.61
Emergency (immediate) shelter	3.22	13.0%	3.33
Halfway house or transitional living facility	3.14	10.0%	3.07
Long-term, permanent housing	2.37	63.0%	2.49
Detoxification from substances	3.63	3.0%	3.41
Treatment for substance abuse	3.87	13.0%	3.55
Services for emotional or psychiatric problems	3.6	13.0%	3.46
Treatment for dual diagnosis	3.4	10.0%	3.30
Family counseling	2.74	3.0%	2.99
Medical services	3.68	3.0%	3.78
Women's health care	3.03	3.0%	3.23
Help with medication	3.41	.0%	3.46
Drop-in center or day program	2.94	10.0%	2.98
AIDS/HIV testing/counseling	3.65	.0%	3.51
TB testing	3.92	.0%	3.71
TB treatment	3.77	.0%	3.57
Hepatitis C testing	3.54	.0%	3.63
Dental care	2.47	13.0%	2.59
Eye care	2.73	10.0%	2.88
Glasses	2.64	3.0%	2.88
VA disability/pension	3.25	17.0%	3.40
Welfare payments	2.61	.0%	3.03
SSI/SSD process	2.91	7.0%	3.10
Guardianship (financial)	2.66	.0%	2.85
Help managing money	2.47	3.0%	2.87
Job training	3.03	13.0%	3.02
Help with finding a job or getting employment	2.97	33.0%	3.14
Help getting needed documents or identification	3.31	3.0%	3.28
Help with transportation	3.05	.0%	3.02
Education	2.71	3.0%	3.00
Child care	2.42	3.0%	2.45
Legal assistance	2.79	10.0%	2.71
Discharge upgrade	2.57	3.0%	3.00
Spiritual	3.34	.0%	3.36
Re-entry services for incarcerated veterans	2.52	10.0%	2.72
Elder Healthcare	2.78	10.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.92
Co-location of Services - Services from the VA and your agency provided in one location.	1.62
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.08
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.92
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.42
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.75
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.92
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.58
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.50
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.75
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.58

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.62
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.15